Co-opting the Global Health Agenda: The Problematic Role of Partnerships and Foundations in Developing Priorities

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Introduction

There is little dispute that the global health agenda is increasingly being shaped by foundations and partnerships, as recognized by the organizers of these sessions. This trend is evidenced through the emergence, or at least rise to prominence, of organizations like The Gates Foundation, Rockefeller, Soros, Carso, etc. Even PEPFAR is, to a certain extent, part of the same global health funding enigma this panel session analyzes. Money in the form of large corporate-funded endowments, in particular, has caused the proliferation of partnerships and foundations, subsequently leading to increasing prominence of the field and secular exposure of the topic. Unfortunately, massive financial endowments and attendant associations do not necessarily lead to improved health, global justice, or sustainable interventions.

As articulated in the abstract for this talk, we aim to problematize the agenda-setting capacity of foundations and service-delivery partnerships, arguing that these organizations are particularly problematic for the following reasons. They:

- Generally do not offer political, economic, or social perspectives in relation to disease causation or prevention
- Focus on individual diseases and technological solutions versus structural interventions aimed at taking seriously the idea of *health*
- Have problematic associations with corporations and 'hard' science, as well as the purveyors of the global 'development' agenda
- Ignore or neglect existing public health services in countries where the 'intervention' is happening
- Have problematic evaluation standards
- Valorize an uncritical idea of charity
- See the contributions of external actors as superior to local knowledge
- Create a problematic knowledge hierarchy

It is important at the outset to state that, of course, not all of these organizations do the above and to lump them all together is unfair. This paper should be read as an expression of concern and seen as an opportunity to articulate some issues that the global health community will need to address to ensure that we do not re-inscribe many failed interventions of the past or, worse, continue a neocolonial relationship between the global north and the global south. If, for instance, global health is revitalizing the mainstream development agenda that has been so soundly critiqued over the past decades (Ferguson, 2006; Lawson, 2007; Sachs, 2005; Stiglitz, 2003), we are witnessing a terrible failure and, worse, injustice for the world's population. The most important messages associated with this paper are: 1) we must be attentive to problematic alliances and connections, monitoring the agenda-setting capacity of partnerships and foundations, especially in relation to problems and solutions, and 2) we know more about health and the ways to address global health challenges than these organizations allow. The route forward does not need to be particularly sophisticated or creative, but it does require a commitment to place health within the widest possible context, one that exposes how anthropogenic forces of myriad kinds create ill-health and suffering globally.

To get this conversation underway, it is important to situate ourselves within this dialogue. We are all geographers at the University of Washington and have been around to witness the inception of the Department of Global Health at our university—from its days as a loose idea to its current structure as a very well-endowed and powerful department at the university. While not wanting to focus exclusively on the Gates Foundation, we have significant experiences with this organization and at the University with which to draw out the critiques below. It would be fair to argue that the Gates Foundation is the lead agenda setter amongst partnerships and foundations, and its influence may even eclipse that of prominent health organizations with the World Health Organization (WHO) in certain circles. Amber Pearson was in the first cohort of graduates with a Master's in Public Health from the Department of Global Health. She has also worked on a Gates-

funded $17 million clean water project at PATH (Program for Appropriate Technology in Health). Todd Faubion is earning a Certificate in International Health through the Department of Global Health, teaches classes in Global Health, and works closely with some of the faculty who have been folded into the new department. Sarah Paige has worked at Department of Global Health on a malaria prophylaxis in pregnancy project with the WHO and Global Fund.

As graduate students, for the past several years we witnessed and participated in conversations as the Department of Global Health formed, realizing early on that we needed to be especially attentive to the influence of The Gates Foundation in 'defining the agenda'. The following type of statement from the Gates Foundation, the principal funder of the Department of Global Health at the University of Washington has simultaneously piqued our interest and been deeply troubling: "We are funders and shapers—we rely on others to act and implement." This is an open, simple expression: they shape the agenda. So, we must ask *how* they shape the agenda, what actors participate in the process, and how this bears out in the lived realities of people subject to the Foundation's interventions.

When there was initial discussion of the possibility of a new department, it was along the lines of a truly multi-disciplinary endeavor designed to bring together the sharpest, most critical, and most substantive contributions of a variety of departments across campus. No department was to take precedence. Yet with the Gates Foundation's contribution of 90% of the dollars to get the department established, it had to fit Gates' vision as a biomedical, technology-oriented enterprise consistent with a corporate business model. As such, the spirit of collaboration was lost very quickly and contributions of the social sciences became peripheral at best. For example, in a move that continues to baffle nearly everyone involved, Jim Kim, of Partners in Health fame, was passed over as the chair of the new department in favor of King Holmes, an internal applicant and HIV researcher whose major emphasis is on condom distribution and circumcision as the key elements of

HIV prevention. The vice-chair, Judy Wasserheit, is an HIV vaccine researcher. And, notably, the department's home is jointly in the School of Medicine and School of Public Health, so it is not the autonomous entity that was originally envisioned. While there are wonderful, critical, and progressive faculty within the department with whom we are all delighted to work, the general approach has greatly narrowed from the days of lofty cross-campus goal setting.

Defining the agenda

One of our general concerns is that the idea of a partnership is not well-formed; the idea is nebulous and the intention is often unclear. There is little evidence of what type of alliances the global health community seeks to build, except that it draws significant nourishment from the corporate model (Fort et al, 2004). Of larger concern is the possibility that partnerships are really another way to bring powerful interests together to have their interests represented across the globe (i.e. big pharma). Furthermore, another sexy term that is emerging relates to public-private partnerships, but we are yet to see much evidence that this is anything other than public support of private enterprise and profit generation (Prentis & Richards, 2004). As such, appropriate questions to ask relate include: Who is setting the agenda? In whose interest does the agenda operate? How and why are certain voices heard and marginalized?

Partnerships and foundations often describe their goals in the following ways (this list was obtained from the Gates Foundation and the organizations it funds—visit http://www.gatesfoundation.org/global-health/Pages/overview.aspx to conduct this query or a similar one):

- Access to or development of vaccines, drugs, and other tools to fight diseases common in developing countries
- Discover new insights useful in fighting disease
- Research to develop health solutions that are effective, affordable, and practical

At first glance, such goals are intuitive, necessary, and just. Yet, the problem we identify is that lack of access and disease prevention models are concepts seen apolitically and absent a focus on global power relations. While these organizations typically come from the perspective that all lives are of equal value, they very rarely examine why these lives are not treated as such (Kim et al, 2000). Consequently, these organizations are a component of what anthropologist James Ferguson has characterized as the anti-politics machine because they neglect to examine why particular populations are disenfranchised in particular places (Ferguson, 2006).

Generally, the emphasis is on the physical environment and alleviation of poverty and its consequences, both of which are anthropogenic and should not be perceived apolitically. As a first instructive example, the resurgence of cholera in South Africa can be considered. Patrick Bond (2004), a prolific researcher on development in South Africa, has documented the reappearance of cholera in rural areas. One possible solution to this problem is for people to be enabled to clean their water or purchase potable water. Another lens—his lens—examines how neoliberal restructuring post-Apartheid (as forced by the World Bank and other development bodies to repay oppressive debts procured by the Apartheid regime) has caused the country to privatize water. Thus, when the poor are unable to pay their water bills, the consequence is service termination and the need to obtain water from unsanitary sources, leading to a cholera epidemic. The Gates Foundation, which does have a focus on diarrheal disease, which is often waterborne, offers only technical solutions like vaccinations, drug developments, and improved delivery systems of those pharmaceutical interventions (http://www.gatesfoundation.org/topics/Pages/diarrhea.aspx). Here we begin to see how foundations like Gates and a social scientist are likely going to have very divergent views on the appropriate course of action in this situation. Because action requires funding, and because people with money typically have corporate associations, one model tends to be pursued at the expense of the other(s).

Furthermore, these partnerships and foundations do not typically define their terms; important terms like 'access', 'effective', and 'affordable' do not have absolute definitions; rather, they are subject to interpretation both on the practical and on the ontological level. Take, for instance, access. What does access mean? Does it related to affordability? Distance? Type of facility? Maintenance of quality stock? Health center schedule? Presence of a provider? If access has anything to do with user fees, evidence suggests that the project will likely fail if it is implemented amongst the poorest (Barnett & Whiteside, 2003; Kalipeni et al, 2004; Fort et al, 2004). Rarely is access defined in terms of social justice (Farmer, 2005). Again, if we examine the idea of access to safe water (an example that will be picked up later), what does 'safe' in safe water access imply? Affordability? At the tap? To be purchased? Universally available? Again, affordable and practical are not well-defined, and are typically differentially applied based on the setting, perpetuating an iniquitous standard.

While we applaud the ethical position that the suffering of the world's poorest is morally wrong, approaches advocated by foundations and partnerships do not necessarily engage why that injustice exists—without the step of examining current material conditions through an historical lens, the ability for progressive change is maligned because underlying structures causing disenfranchisement remain intact. The larger issue here, then, is that priorities are determined externally by people with a particular *ideological* perspective—that being a belief in the virtues of technology, a business model, and placing a supreme value on the market. We emphasize ideology here in an effort to draw a synergy between the new global health agenda and the decades-old global development machine that has been in place since the post-WWII era (Crush, 1996; Escobar, 1994; Ferguson, 2005; Lawson, 2007). Few would argue that what Gillian Hart has called 'big D' Development has served to alleviate large-scale suffering globally, yet it continues unabated as a consequence of belief in the virtues of the capitalist model (2002). We argue that partnerships and

foundations are, on the whole, perpetuating this deeply problematic mould. Global health interventions must not be directed by ideology, but by sound research attentive to conditions fostering ill-health.

A Troubling Knowledge Hierarchy

One of our fundamental concerns is that allies and projects are determined by the foundations and partnerships, rarely with local knowledge or contributions; furthermore, interventions are being implemented in places where there were formerly high quality services that have been eradicated in the structural adjustment era (Gloyd, 2004; Farmer, 2005). Besides the above-articulated issue of seeing the world through apolitical lenses absent a focus on power relations, an approach based on giving and charity valorizes the contribution of external actors, reproducing discourses of need and dependency while infantilizing the global south. This is not a new phenomenon, but we think it is being exacerbated as more and more money gets linked to technology firms and big pharmaceutical organizations that are often the major benefactors of research and development grants from, in particular, foundations.

As a consequence, problems are defined for the recipients of aid, as are the solutions. Little emphasis is placed on local knowledge or buy-in in the success of projects. There is little follow-up to measure success. Ultimately, this creates a problematic knowledge hierarchy, one where this is little capacity for knowledge transfer, especially if communities and funders have different aims and different conceptions of problems, needs, and solutions (Fort et al, 2004; Pfeiffer, 2003). Furthermore, as alluded to above, there is an inherent presumption that solutions that have worked in the past are no longer practical; a total ignorance of what past structures looked like and how they did/did not serve populations in need obscures the fact that people everywhere are able to be healthy with the appropriate health *structure*, and it is rarely based on the provision of technology

(Pope et al, 2008). Particularly troubling is ignorance related to simple public health-oriented messages and the key ideas around which healthy populations are centered: education, access to health care, democracy, and other basic entitlements. Our position is that we do not necessarily need innovation—we know what works already.

Program Creation & Evaluation

A further challenge we would like to convey relates to program creation and evaluation. Not only are partnerships and foundations emerging as powerful forces in the shaping of the global health agenda, there is very little analysis of a) their actions, b) the efficaciousness of their programs, or c) their ability to achieve lasting interventions (Pfeiffer, 2003; Pfeiffer et al, 2008). A major element missing in program creation and evaluation is time. Time frames are always too short, meaning projects are rarely successful; operation on a timeframe and failing to interact with existing health structures means programs struggle to endure. Additionally, there are intense demands placed on funded organizations to show results in the 2- to 5-year timeframe; turning the health of a population around in this period is virtually impossible. Too much effort goes into demonstrating what the intervention has done, not if it is sustainable or locally supported. Evaluation indicators that do exist often reflect service (number of patients seen, number of injections given), not health outcomes as a way of demonstrating how one project's or one donor's money is being spent and not on how the money may be improving lives. Inferences made from service indicators may have nothing to do with actual health status. Furthermore, there is no requirement of transparency with evaluation mechanisms, little sharing of information, no requirement for fair wages to those hired in host countries, and no requirement for actual research training and competency for those heading research teams. Lastly, evaluation tends to be about pleasing donors, not providing services to populations.

Technological Solutions for Social Problems

The last basic area of concern we would like to touch upon relates to the way in which technological solutions are becoming stand-ins for socially-oriented interventions cognizant of local cultural, society, economics, and politics. As a basic function of the need to fundraise, most partnerships and foundations valorize innovation above pragmatics, presuming that we do not already know of solutions that work and have worked for decades or longer. Our claim here is driven by a project Amber Pearson worked on at the Program for Appropriate Technology in Health (PATH). PATH's Safe Water Project created market-oriented solutions for people making $1 to $5 per day to purchase resources to clean their water, including pens and other forms of technology. Yet, such interventions do not address *why* people do not have access to clean water, nor are they part of a sustainable solution, especially for the world's poor who would already be paying for safe water if they could afford to. Furthermore, organizations like Gates endorse and fund vaccine research, but do not critique the global capitalist structure that will prevent the majority population from accessing such vaccines if they do come available on the open market.

It is important to inquire as to why the Gates Foundation takes such a position and how this emphasis has developed. To do so, we reviewed the organizations website to identify the major actors at the Gates Foundation, those shaping the agenda. In the case of Gates, almost all of the board has business, finance, mainstream development, or pharmaceutical interests. For instance, the general board members have the following associations: Microsoft, the World Bank, Costco, a former Treasury Secretary, general finance, GlaxoSmithKline, the Bank of California, international law, Lazard (financial and asset advising), and Information Technology. Not one board member is an academic, not one comes from a background of examining poverty, inequality, gender, violence, or geopolitics. They are trained in particular schools of thought that are reflected in the organization's approach to lending and health improvement. The global health leadership team is

similarly focused: their experts come from the World Bank, general business, a former adviser to Al Gore, Biospect (a technology company), human genome research, law, Zymogenetics, vaccine development, the National Institutes of Health in Mexico, and biodefense with the Bush administration. Two health leaders, Peter Piot and Bill Foege, are important exceptions that stand as luminaries in the global health field, though were one to hear Bill Foege speak today he would be advocating for increased technological research and public-private partnerships. While the global health team is considerably more health-oriented, there is still peripheral representation of public health, social organizations, poverty, the academy, etc., which again attends to the fact that the model is one fostered by the market and business principles.

Ultimately, leadership comes mostly from the private sector *because of the belief in the virtue of this model*. Even when leadership is not from the private sector, they are people trained in particular natural science, specifically the biomedical tradition. Furthermore, very few members of leadership at Gates and similar organizations have applied training with vulnerable populations and no exposure to basic tenets of public health philosophy. As such, under the organization's dominant rubric, wealth creation and harnessing of the market leads to good health. Another pertinent example is that the Gates Foundation has donated $1 million over two years to the Global Business Coalition to fight AIDS, again yoking the business model to its global health agenda. Most troublingly, this model places human lives into the rubric of cost/benefit analysis. Yet the examples of wealth creation *not* leading to good health for the majority population are myriad (Goldman, 2005; Sachs, 2005), especially for those ensnared by debt created by the development enterprise. The creation of wealth does not say anything about who holds the wealth, nor how it is distributed. The simple fact is that there is little evidence that more wealth in the world translates into enhanced health care access or improved well-being for the poor (Stiglitz, 2003). The question of distribution is much more salient.

Conclusion

When considering solutions to global health crises, we need to take seriously the idea of 'health', expanding the conversation beyond a strict focus on disease. To do the latter eclipses the need to think structurally. To do the former first requires that we ask why people are ill and why they are not able to prevent the threats the global health community purports to address. Without basic entitlements, people are typically forced to pay for services. Unfortunately, under this rubric there will *always* be those who are too poor, further marginalizing those in poverty. An understandable response to this claim might be along the following lines: "Governments are failing to provide for their populations; corruption and despotism persist, causing the majority population to be violently disregarded. We are just stepping in to fill the void, using the best tools in our toolkit to keep people alive." Unfortunately, this perspective misses the point. We all allow injustice to exist in the world and are all responsible for conditions elsewhere, particularly in postcolonial Africa. Extreme debt, for instance, causes most countries in the global south to adopt structural adjustment policies that malign public health services (Kim et al, 2000). Yet the debt itself is due to misguided Development interventions that were originally rooted in Western attempts to control global capital and politics. A fuller picture answers the question about what needs to be done for real, sustainable solutions, and foundations and partnerships can only be a part of this agenda if they adjust their focus.

It is further deeply problematic to hand the agenda over to organizations so tightly linked to the global capitalist system, especially when there is no oversight body to ensure the work they conduct is just, ethical, and efficacious. Researchers responding to this concern at the University of Washington, notably *within* the new Department of Global Health, are attempting to forward the idea of an NGO code of conduct that would standardize some operations and create baseline

evaluation standards (Pfeiffer et al, 2008). Several examples other attempts to come up with baseline standards for NGOs and other global health actors are cited below.

To continue to place confidence in partnerships and foundations fails to recognize the relational nature of health; that is, ill health is created and we know of the interventions that can successfully address ill health. In Africa, for instance, the often-cited major health threats are HIV/AIDS, malaria, tuberculosis, and diarrhea, among others. Yet all are endemic to the United States; they are controlled through basic health services that only sometimes involve access to medicines. We believe that the challenge as we move forward, given that partnerships and foundations are likely here to stay due to their massive financial endowments, is to see this light—a light that exposes why interventions are needed in the first place.

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